SEP 13 1934

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

21389

1. PLACE OF DEATH
County Pemiscot Registration District No. 653 File No. 67
Township Primary Registration District No. 4390 Registered No. 67
City Hayti (No. St. Ward)

2. FULL NAME Lemyal Brooks

(a) Residence, No. St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) infant
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10/3/1932
7. AGE YEARS — MONTHS 8 — DAYS 2 — If LESS than 1 day, ...hrs. or ......min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. infant
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hayti Mo

FATHER
13. NAME Lee Brooks
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Greenwood Miss

MOTHER
15. MAIDEN NAME Beatrice Walloc
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss

17. INFORMANT Lee Brooks
(ADDRESS) Hayti Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Morgan Cem DATE 6-6 1934

19. UNDERTAKER D. J. Smith
(ADDRESS) Hayti Mo

20. FILED 9-10 1934 JW Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-5 1934

22. I HEREBY CERTIFY, That I attended deceased from 4-19 1934, to 6-5 1934

I last saw h... alive on ......, 19... Death is said to have occurred on the date stated above, at 5 P.m.

The principal cause of death and related causes of importance were as follows: Date of onset

acute Lymphphagitis
101
29A

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) JW Rhodes, M. D.
(Address) 6-5-34

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

#2

Pneumonia

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.
67

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Lenyal Brooks
Who died at _____ on June 5 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex M Color or race B Single, ~~married, widowed or divorced:~~ _____

Date of birth _____ Age: Years 0 Months 8 Days 2

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

~~Date deceased last worked at this occupation:~~ ~~Month~~ _____ ~~Year~~ _____
~~Birthplace (State or country)~~ V
~~Birthplace of father (State or country)~~ _____
~~Birthplace of mother (State or country)~~ _____
Principal cause of death: Acute Lymphadenitis. Perhaps T.B. of Cervical Glands

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____
Address of physician _____
Signature of Registrar J. M. Rhodes Date filed

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 653

Primary Reg. Dist. No. 4390

Very truly yours,
E. T. McGaugh M.D.
S.C.
Special Agent.

5-21389